

PEER REVIEW IN PSRO

Non-Physician Health Care Practitioner Conference

SEPTEMBER 5, 1974 • PARKLAWN BUILDING • ROCKVILLE, MARYLAND

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Office of the Assistant Secretary for Health
Office of Professional Standards Review

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Introduction

At the request of Dr. Henry Simmons, Deputy Assistant Secretary for Health and Director of the Office of Professional Standards Review, a Non-Physician Health Care Practitioner Conference on Peer Review in PSRO was convened on September 5, 1974, in Rockville, Maryland.

The 20 national organizations which took part in the Conference represent professional disciplines composed of more than one and one-half million individual health care practitioners. It was realized, during the day, that never before had so many various disciplines come together to consider the problems and advantages of health care peer review. Because of this, as well as the high caliber of the individual presentations, it was decided to publish the proceedings of the Conference in the present format.

After introductory remarks outlining the present status of the PSRO program, the private organizations presented individual progress reports in random order. Those oral reports have been somewhat edited here. If, in changing from the spoken to the written word, some unevenness of editing has occurred, we apologize to the speakers. The recommendations of the Conference work groups, which addressed several specific problem areas, are currently under analysis by the Department.

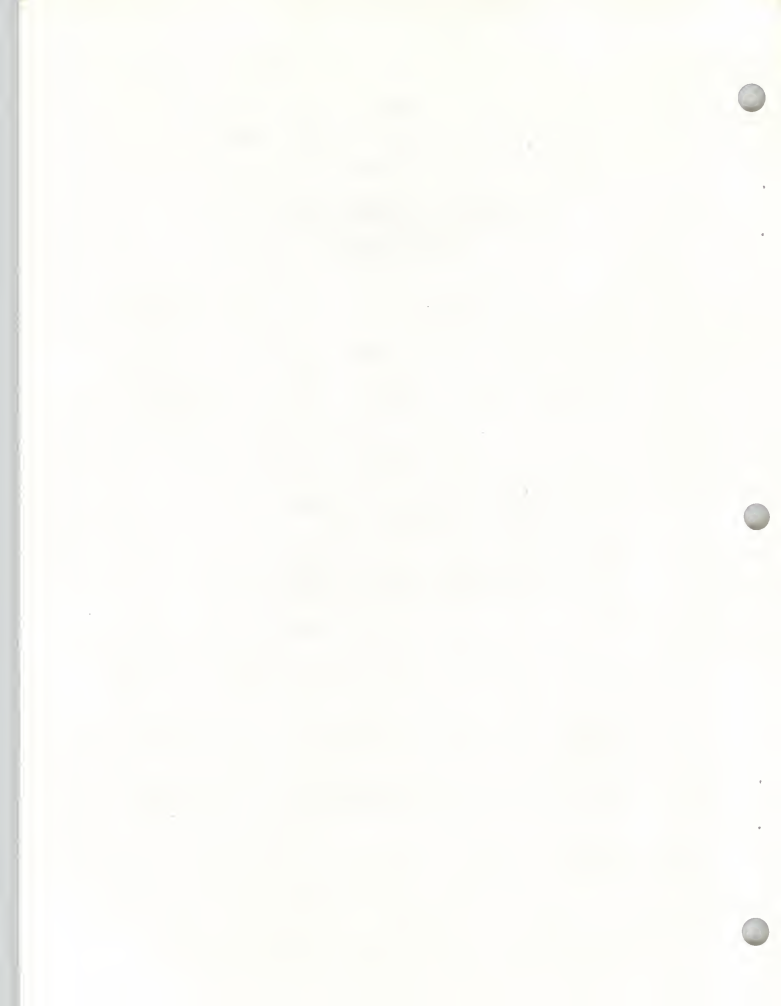
John R. Farrell, M.D.
Office of Professional Standards Review

AGENDA

NON-PHYSICIAN HEALTH CARE PRACTITIONERS CONFERENCE
ON
PEER REVIEW IN PSRO

Thursday, September 5, 1974
Conference Room G, Parklawn Building
5600 Fishers Lane
Rockville, Maryland

9:00	Welcome and Introductions	Dr. Farrell
9:10	Current Status of the PSRO Program	Dr. Simmons
9:30	Components of PSRO Review System	Dr. Goran
10:00	----- COFFEE BREAK -----	
10:15	The Role of the Non-Physician Practitioner in PSRO Medical Care Review	Mrs. Ellis
10:45	Roundtable Presentation of Current Review Activities by Participating Organizations	Dr. Farrell
12:15	Delineation of Issues for Discussion Groups	Mrs. Ellis
12:30	----- LUNCH -----	
1:15	Small Group Discussions of Non-Physician Review	Conference Rooms C, G, K and 16A-43
3:15	Presentation of Small Group Recommendations by Recorders	Dr. Farrell Mrs. Ellis
4:30	Adjourn	



ATTENDEES

NON-PHYSICIAN HEALTH CARE PRACTITIONER CONFERENCE ON PEER REVIEW IN PSRO

September 5, 1974

<u>Name</u>	<u>Affiliation</u>
J. Harold Bailey	American Optometric Association
Lois A. Bernbeck	American Association of Nephrology Nurses and Technicians
William E. Cox	DPSC
Dr. Richard F. Curlee	American Speech and Hearing Association
Pearl H. Dunkley	American Nurses' Association
Carol Eady	National League for Nursing
Betty R. Erlandson	American Nurses' Association
Helen Foerst	ONHA/H
Marvin L. France	International Society for Clinical Laboratory Technology
James M. Friedman	OPC/H
Mary Jo Gibson	SRS
Jack Grady	SRS/MSA
Fletcher R. Hall	National Rehabilitation Association
Don Harrington	BCHS/DCS/MCHS
Mary Frances Hilton	OPC/OASH
Winona Hocutt	BHI/SSA
Al B. Honick	BHI/SSA
Raymond W. Horner	American Society of Radiologic Technologists
Thomas Hoyer	BHI/SSA
Alan Kaplan	PSRO Letter
Ward Keller	American Society of Radiologic Technologists
Katherine Kendall	BCHS
David Krigstein	American Pharmaceutical Association
Martha Leonard	American Association of Nephrology Nurses and Technicians
Ralph Nemir	American Psychological Association
Geraldine Norris	OMCH
Patricia Ostrow	American Occupational Therapy Association
Richard C. Paul	American Association of Bioanalysts
Dr. Richard P. Penna	American Pharmaceutical Association
Mary Ann Poole	American Occupational Therapy Association
John S. Prickett, Jr.	National Rehabilitation Association
Dr. Louis A. Reibling	American Society of Allied Health Professions
Dr. Claife Ryder	ONHA
William Samuels	American Society of Allied Health Professions
Dr. Bernard J. Shannon	American Optometric Association

Dr. Frederick T. Spahr

Dr. Michael H. Stolar

Wilma West

Dr. Esther Winterfeldt

William K. Young, Jr.

David Zilz

American Speech and Hearing
Association

American Society of Hospital
Pharmacists

BCHS

American Dietetic Association

American Medical Technologists

American Society of Hospital
Pharmacists

CURRENT STATUS OF THE PSRO PROGRAM

HENRY E. SIMMONS, M.D.

Deputy Assistant Secretary for Health and
Director, Office of Professional Standards Review
Department of Health, Education, and Welfare

To begin, I would like to thank you all for coming to this meeting. This is one of a series of meetings that we have been setting up under Dr. John Farrell's direction to help us open the chain of communication to all the important groups in the private sector, all the important organizations that we see as having a potential role in the PSRO program.

The purpose of this specific meeting is to give us an opportunity to candidly and directly tell you what we think PSRO is all about, then to ask you to respond and say, "Given what we hear is your understanding and given our own perceptions from how we have read the legislation and how our constituencies feel about it, here is how we think we fit into PSRO and how we think we can be helpful to the nation, to the health care system." So, it is a two-edged meeting, one where we get the opportunity to talk to you but, more importantly, where we get to hear from you about how you think you and your organizations fit into this program. We are certainly not smart enough to have figured out all the answers to this and other key questions that still face us in the program. I don't feel embarrassed or apologetic because, after all, PSRO probably is the most important piece of health legislation ever enacted. I think its potential for the good it can do in the health care system is unparalleled. The possibilities it has within it, if properly administered and properly directed by the private sector, which is basically from where the direction and the implementation of this program is going to come, are unlimited. At the same time, if it is not properly administered, if the private sector doesn't come forward and do the job, it could be a very great failure and a very great waste of resources. I don't think it will be. I don't think it need be. And it won't be if you in the private sector, who eventually have to get the job done on the public's behalf, understand what it is about.

So, what I would like to do at the opening of this session is to give you the same kind of briefing we have been

giving other health professionals and others in the Department, after having studied the program for a year, on what we think it is all about, what the problems are as we see them today, how this program will impact on them, and where we stand in the program today.

The program is fortunately progressing very rapidly. We already have PSRO activity in all but six states in the country, and I think that gap will be closed this year. We have over 115 organizations under contract in the program and there are actually 11 conditionally operating PSRO's in the United States, right now, reviewing care and making judgments. So, something that went from a perception and a dream and a theory two years ago is now a reality and will rapidly become more of a reality as PSRO blankets the nation and takes on the review responsibilities that currently exist under other parts of the law. I would like to give you some background as to what we see as the major problems facing you and all of us, Government and the private sector, in the health care system. They are as follows:

Nobody who ever reads a newspaper can ever escape the significance of this. There is massive and rapid escalation in the costs of medical care, not only through Government programs, but also in the private sector, enough so that there is a lot of fear as to how long this can continue and what we need to do about it. It is real, it is getting worse, it is out of proportion to the problems in the rest of the economic system.

We have seen, through Federal programs in the past -- Medicare, Medicaid -- since 1965, that what has happened is a marked increase in the number of services and the cost per beneficiary, but not enough evidence of population benefit by at least the gross measures that we have available to us. We haven't seen much of a change in mortality or other measures where we would hopefully expect improvement with that kind of expenditure of resources.

There is increasing evidence, and more and more objective studies are coming into the literature, of poor quality and an irrational use of our very expensive and increasingly scarce physical and human resources. We do know, through the same kinds of studies, that there are some major adverse effects to the population, many of which are preventable. Included are adverse reactions to drugs which are harmful, which at times cause irreparable damage to the population

and at the same time are extremely expensive. There are estimates made, as you know, extrapolations from small studies -- which are always subject to error -- that we may be near the point where between one-tenth and one-seventh of all the hospital days spent in this country are in taking care of people who went there because of drug reactions, many of which, though not all, are preventable.

We do know that although hypertension is a major problem in this country, with estimates that there are 20 million of us who are hypertensives, we only have identified about half of them; and of the half we have identified only half of those are under treatment; and of the half who are under treatment, only half are being treated adequately. Which means that in a disease that strikes one in every ten Americans, only one-eighth of them are under adequate treatment, despite the fact that science has given us the tools to control this disease. Here you have an interesting cost-benefit kind of judgment. The National Heart and Lung Institute and its councils and the professions working with it have done some fairly sophisticated studies which suggest that it's not a matter of society saving money by not giving care. The fact is that if society doesn't figure out a way to deliver quality care to those who need it, in the end society pays a larger bill than otherwise. If we could give the care that we know how to give in hypertension today, it would cost society and the system about \$3 billion. If that care doesn't get delivered, society will still face a bill through crippling, through early death and through illness that's preventable of about \$7 billion. So the cost-benefit relationships in quality care are reasonable and appropriate for society to assume, and that's just one example.

We also know that there is a major waste in the present system through malpractice problems and defensive medicine. The premiums alone for malpractice, which the professions are now paying, I believe are estimated to be over a billion dollars. Most of that is passed on to the consumer, and unfortunately estimates are that only about 20 per cent of that ever gets back to the consumer in the payment of a claim. So, there are major problems facing professionals, most of whom are trying to practice good medicine despite the growing problems. Other estimates are that defensive medicine alone is consuming about ten to fifteen per cent of the Nation's health care dollar. And defensive medicine usually is not reasonable medicine. It is care being delivered though the profession knows it is unnecessary,

because of a fear of the unknown, of a malpractice suit.

We do know that there is rapid inappropriate innovation dissemination in the system, and unfortunately a slow elimination of obsolete procedures from the system. Just a small and maybe mundane example of this is the fact that after about seven or eight carefully controlled clinical trials showing that bed rest for acute hepatitis contributes nothing to the outcome of the patient, a sample recently done in several hospitals in New York showed that 40 per cent of the patients with that diagnosis are still admitted and placed on bed rest.

We also know that unfortunately there is a lack of data, lack of intelligence on the health care system by which we can compare outputs, outcomes, and regional variations. We just don't know what's going on in the system to the extent we need to know to decide how to spend \$100 billion of the public's funds intelligently. When you talk about spending eight to ten per cent of the gross national product which, if present trends continue, will soon go up to 12 per cent, you realize the tremendous need for some kind of data on the system so that you, and we in government, can make intelligent decisions on how to spend those dollars on the public's best behalf. Because there is an inadequate data base, there is inadequate pressure from the public to change the system. If they don't know what's going on, it's very difficult for them to respond intelligently either to use the system properly or to force that system to come under some kind of change.

Compounding all of this is the fact that society and our elected representatives appear to be coming to the public decision of having national health insurance. Whether it comes this year, next year, or two years from now really isn't particularly material any more. The fact is that it appears it will come. And if you think that we have problems now in not knowing how to use our health system most efficiently and most rationally, just imagine the potential there will be when the entire nation's health bill is paid out of public funds.

So, it makes it increasingly important for all of us who are worried about the health care system and want to make it better to put in place some kind of rational system of quality assurance. Then the public, the government, and the profession can be assured that whatever we spend in health care in this country is spent intelligently and is

spent in areas where we can get the biggest yield. And it isn't asking too much of you in the private sector and those in government to do. That's a legitimate question placed to us. Also, we have, I believe, good evidence of the fact that the existing systems of utilization review are not working. There are pockets of excellence, but there are huge gaps where it appears the system is very marginally functional.

So, for all these reasons we have, under the legislation in this country today, PSRO. The PSRO was put here to help correct many of the preceding problems. The allegation is made that the only reason PSRO is here is to control costs. I certainly would vigorously defend against that kind of assumption. I don't think that any kind of cost control system would first ask the private sector to do what PSRO is asking. First of all, it's unique in that it's the first time the federal government has turned to the private sector and said, "There is a tremendous problem and we are giving you in the private sector the first chance to bring it under some kind of control. If you do the job, government will stay out. If you don't do the job, government will be forced in, because when there are public funds being expended, they must be expended in some kind of a publicly accountable way." There is no way that government can fulfill its responsibility and not see that there is in place some system to see that those funds are spent intelligently.

What PSRO does is certainly not what has been done in the past. The intermediaries, the carriers and the insurance companies, have been relied on by government to do this job. It hasn't been working as well as it could. Senator Bennett said let's move in another way. Let's go to the private sector, give them the resources, the authority, and the responsibility to do the job, hold them publicly accountable, and give them the first chance. And that's the opportunity PSRO holds for those of us in medicine and for you in the private sector specifically. Basically PSRO is there to help control and correct most of the problems I have talked about through the development of a nationwide system with sufficient resources, a data base, authority, and the responsibility to assure four things:

One: That there are objective standards of medical care developed by the profession and updated as necessary.

Two: That the profession assures those standards are adhered to appropriately.

Three: That you identify areas where the standards are not being followed and find out why. If there is an appropriate variation, fine; that care certainly should be paid for. If it's inappropriate, your job is to find out why, to mount corrective educational programs and, if necessary and as a last resort after education doesn't work, to recommend sanctions be applied.

Fourth: And maybe the most important thing, is to see that whatever care rendered in this country is rendered in the most appropriate setting so the dollar will go farthest in adequately impacting favorably on the public health.

That is what PSRO is called on to do. And in so doing it can in fact have a major impact on improving the medical care delivery system. Finally, it gives the government the ability to have in place a system that can adequately account for the expenditure of large amounts of public funds. It is true that at present the PSRO program applies only to 50 million Americans. That is quite a few but it isn't the whole country. The fact is its importance even today far exceeds the limited beneficiary group with which it is working because it is very likely that the profession, in sitting down to develop adequate standards of care, will apply those same standards to every American receiving care. So, even today under its limited mandate, it will still affect the entire health care system in this country.

What are PSRO's potentials then? We see them in a number of areas. We know from the operation of prototype organizations this isn't a new untested kind of theory. We do know from the operation of experimental programs in the past, that it can improve quality, that it certainly can improve efficiency, and that it can effect appropriate economies. It can also be the vehicle that brings more rapid innovation of appropriate changes into the medical care system and roots out obsolescence faster. Because, after all, the profession has the mandate to not only set standards but to modify them as rapidly as appropriate, to change what was previously thought to be a good judgment.

We do think the PSRO structure will have a very significant and beneficial impact in the defensive medicine area and in the malpractice area. It certainly is going to provide a data base on which those of you in this system and those in government can finally understand what is going on and with what yields, so that intelligent decisions can be made.

And finally, it will provide a part of a system that will be needed to help make national health insurance really work.

How is the program progressing? As I have told you, it's operational or in the planning stage in all but six states. We already know that there are at least fifty other PSRO areas in this country that want to come in for planning contracts during this present fiscal year. There is a very large operation going on right now within government in the Social Security Administration, in the Social and Rehabilitation Service, and in the Health Services Administration to help develop a coherent program on behalf of the federal government. The job of the Office of Professional Standards Review is to see that this program is intelligently administered and appropriately implemented on behalf of the Department. It is a very fascinating job, let me tell you.

We have a very substantial amount of work going on in the program right now in all segments of the health professions. Every major national physician specialty society is now working on critical screening criteria for concurrent and retrospective review. A major training contract has been awarded for the training of professionals who will administer and be responsible for the PSRO programs in the country. We have a major contract with four major specialty organizations to develop new antibiotic standards where it is thought there are important problems. We are very pleased that the private sector through the Kellogg Foundation and other foundations is already doing important work. The Kellogg Foundation is going to study six prototype PSROs under a million dollar grant to determine the best way to get the public involved in the PSRO movement and how the PSRO movement might best be set up.

We have a complex problem internally to integrate the existing and proposed utilization review systems with PSRO, so that we have coherent requirements. We know there is confusion in the private sector because of different requirements currently placed on them under Title 18, Title 19, JCAH and PSRO. What we are trying to do is to make this a sensible program that melds all four requirements it has to meet for all purposes. I am convinced that we will successfully bring that about. There are already some very important changes in that direction.

So, basically things are going well. There are a few thoughts I would like to leave with you. It is certainly

clear, at least to me, that quality assurance is no longer a part-time activity. It just makes no sense at all to expend \$100 billion in a health care system and expend almost nothing in the way of funds to assure the quality of that system. PSRO has now said that's true, quality assurance is nothing you do out of your back pocket on a shoestring budget with part-time people or out of public good will. It's complex, it's important, it's sophisticated, it has got to be run as a full time program. That is what PSRO is about.

I think it's important for you in the private sector to understand that fact for it's important that these kinds of quality assurance programs be just as adequately funded as research programs currently are accepted to be by the public. Those of you in the private sector will have to see to that. It's very important that you put your very best people in PSRO and not put somebody who is ready for retirement or ready for nothing to do. It's too important for that. You can't let PSRO, which is going to be managed by the private sector, be managed by somebody who doesn't have the energy and the leadership to do the job. If you study the legislation and see the potential there, it may be the last opportunity for the private sector to do something important in the health care system. All you have to do is study other legislation that is proposed or being contemplated and you can see that if the private sector doesn't take up the job, our representatives are ready to turn to somebody else. I don't believe that the others they would turn to have as much potential to succeed as you do. That's why I think it's important and that's why I am glad you are here and that's why we hope to get some ideas from you at this meeting on how it can be improved. Thank you very much.

COMPONENTS OF PSRO REVIEW SYSTEM

MICHAEL J. GORAN, M.D.

Director, Bureau of Quality Assurance
Health Services Administration
Department of Health, Education, and Welfare

What I would like to do in addition to welcoming you this morning and indicating our expectations -- that this be a working conference and that you provide us with ideas, because we surely need them -- is to consider with you the basic outlines of the PSRO review system which at this point in time is primarily a system dealing with hospital care and primarily dealing with physicians. That's the reason for this conference, to begin to broaden the purview of the program.

I will apologize right from the beginning; I know looking around the room that many of you have heard much of what I will have to say before, but I think it's worth repeating, and I know that some of you have not heard it.

What I would like to do is begin with a brief review of the legislation. As you will recall, this statute mandates that PSROs be responsible for review or quality assurance of all insitutional services. We administratively restricted the initial purview of PSROs to hospital care because of two reasons. The first is that there is more known about how to do hospital review, the techniques are more sophisticated. Second, we believed the step-wise approach to the development, the evolution of a quality assurance system would in the long run prove more beneficial to the public than attempting to take on the whole job all at once.

There will obviously be exceptions to the rule, as there are to any rule, in those PSROs that are already competent and have been performing review in the past. They will be able to move more rapidly out of the hospital setting into the long-term care arena and even into ambulatory care. I should just remind you that PSROs can only do ambulatory review at their own request and with approval by the Department. It is not something that the Department, given the current statute, can require of PSROs. It's an option. Nevertheless, it's clear the the intent of this statute -- and I think Dr. Simmons has indicated quite eloquently -- is to develop a community-based quality assurance system that

is comprehensive in scope and does indeed involve not only the federal beneficiaries but all patients either through direct participation by the private, non-profit, and commercial third parties or through national health insurance; and the system should in fact touch upon not only institutional services but all care.

But today, and I guess for the rest of this year and probably the following year, PSROs will primarily be affecting hospital care. And in the hospital setting what PSROs will be attempting to do is implement what we consider a comprehensive quality assurance system within the hospital. This system is described in some detail in Chapter 7 of the PSRO Program Manual, and I will briefly outline its major features. The hospital review system consists of three review mechanisms. They are concurrent review, medical care evaluation studies, and pattern and profile analysis. You should consider each of these components as a part of a whole. It is true they stand on their own but they are also integrated, one interacting with the other.

By far the most expensive in terms of manpower and time is the concurrent review component. Yet it functions better when it's integrated with the pattern and profile analysis and medical care evaluation studies component. The three systems are used to serve the two major purposes of the PSRO program which are quite simply to assure quality of care and to assure appropriate utilization of services. Against these two purposes the concurrent review system is primarily directed towards assuring appropriate utilization. The medical care evaluation studies component is primarily directed toward assuring quality of services. Profile and pattern analysis is the feedback mechanism. It's the monitoring device that the PSRO itself uses to determine how well concurrent review and medical care evaluation studies are performing. What are each of these mechanisms?

First of all, they are really the 1970's version of peer review. They have evolved over the last decade or so and rely upon some basic concepts of peer review that have developed, the most important being peer review performed by the profession itself on a local basis so that objectivity can be retained on the one hand but involvement elicited on the other. The PSRO concept is external to the hospital so the colleague situation can be avoided but still local so that in fact you can get involvement of practitioners that do know each other and work together.

Second, the concept of the use of explicit criteria is fundamental to all components of the PSRO review system. It's a very simple concept. Basically it means that in order to conduct a review, the PSRO has to set standards, expectations, parameters of care that it believes it should and can meet and uses these standards to operate the review system.

Third, the review system functions on a screening basis, relying heavily on the use of full-time personnel whose full-time function, as Dr. Simmons indicated, is to do review work. They screen out cases with patterns that should be brought to the attention of the peer review committees themselves, the physicians. This concept, in the most sophisticated form today, takes the shape of a team consisting of a review coordinator and a physician advisor. This team, basically, makes the concurrent review system work and also to a large measure supports the medical care evaluation studies component in most of the prototype PSROs.

The concurrent review system is a system that has two parts, the first admission certification and the second continued stay review. Both parts, as I indicated before, are designed to address assurance that services are utilized appropriately. The first part of it, the admission certification, is concerned, of course, with assuring medical necessity of admissions to hospital level care. Basically what happens in a concurrent review system is that the beneficiaries of Medicare, Medicaid, and Maternal and Child Health and Crippled Children's programs who are admitted to a hospital are subject to the admission certification process in which criteria relating to the need for admission are applied to each admission and, as a result of that process, admissions are either certified as being medically necessary or questioned. Questioned cases are referred to the physician advisor who in turn either certifies or denies the need for admission. In all instances, whether it be an admission certification or a continuing stay review, denials or adverse decisions can only be made by peers -- the physicians. Decisions to certify, however, can be made by the review coordinators.

I think most of you know there is an elaborate process for contesting decisions that we are currently developing. It's called the reconsideration process, and ultimately it ends up with access to the courts through an appeals mechanism. It's designed to protect the patient, the

physician, and the institution. But the basic thrust of the system is contained within the review coordinator and the physician advisor where the initial decisions are made and usually hold. Once admissions are certified a checkpoint day is assigned. This is based on norms developed by the PSRO, and what it does is certify payment, certify that care will be paid for up to the checkpoint. The patient is admitted and on the basis of the admitting diagnosis the checkpoint is usually applied. It certifies payment and it also triggers the next time review will take place. It triggers the continuing stay review process, in other words. It's a patient-specific approach. Most of you are familiar with the fact that currently, under Medicare, utilization review has and does require extended duration review. It usually however is not on a patient-specific basis but rather uses an arbitrary date that often is unrelated to patient needs. The PSRO approach, which takes into account the actual problems of each patient, allows for the establishment of checkpoints in time that are more realistic and therefore make the review process itself more productive.

With continuing stay review the same process is repeated. Those patients still in the hospital at the checkpoint day are reviewed by the review coordinator, again using criteria. This time the criteria focus more on indications for discharge than indications for admission. If the criteria are not met, or the review coordinator has a question that continued stay is not warranted, referral is made to the physician advisor and the process is repeated. It usually involves a consultation with the attending physician and a decision of either to grant an extension and assign a new checkpoint or to deny continued stay.

The teeth of this whole process is obviously the relationship of the decisions to the financing system, and it's important to understand that the PSRO system carries with it considerable responsibility and a new authority. Decisions made by PSROs are binding upon Medicare and Medicaid payers. The whole intent of the program is to turn over responsibility for making decisions regarding medical necessity and quality to the professions. If they exercise judgments through this process, they will be binding upon the third-party systems -- that is, intermediaries and fiscal agents will not be able to overturn or overrule decisions made by this PSRO or the PSRO system. This does not mean, of course, that PSROs make decisions regarding eligibility for services, scope of coverage, or amounts to be paid out. These remain the

responsibility of the third party.

That's basically the concurrent review system. It focuses, as you can see, on the use of hospital level care -- at the front-end, admissions, and throughout the stay of the hospital episode, trying to make sure that lengths of stay are appropriate, not excessive. It involves, as you might imagine, an intimate relationship with discharge planning, recognizing quite clearly that some of the problems with extended lengths of stay have to do with the lack of alternate placement facilities. For the concurrent review system to work well, review coordinators and physician advisors must be working closely with the social services departments of the hospitals to determine the alternate placement facilities available.

In addition, there are some variations that I think are worth mentioning, essentially additions to the concurrent review process that most PSROs move toward as they gain experience. First, during the concurrent, continuing stay review process, many PSROs find it beneficial to look at more than just need for continued stay in the hospital and to examine issues more germane to quality itself; to look at, for instance, use of ancillary services, use of antibiotics or other drugs, to use the concurrent review process to collect information for medical care evaluation studies which I shall describe later. In addition, from pattern and profile analysis and medical care evaluation care studies, each PSRO working with each hospital attempts to focus or design the concurrent review system so that it's responsive to the needs of the individual hospital. The system itself is designed through interaction between the hospital and the PSRO.

In order to answer the question of should the PSRO run the system or should the hospital be delegated responsibility for review, any hospital that is capable and willing to perform review can be delegated review by the PSRO. In order for this to take place, the PSRO must assess the capability of the hospital. During that assessment process it should get an understanding of the needs of each individual hospital. For example, the admission certification process should be designed on the basis of need. Hospitals with low occupancy rates, hospitals that have problems with unnecessary admissions which are documented through medical care evaluation studies, will obviously need more emphasis placed on the admission certification component than hospitals with high occupancy rates and no history of

problems. Similarly, hospitals with no documented excess in lengths of stay will need less attention to the continuing stay review process.

So, part of the assessment process itself should be designed to determine each hospital's needs. The reason I raise this is so that you get the impression that the concurrent review process, while it has some structural features, is a very flexible process that is supposed to evolve over time. The process should have impact on correcting aberrant behavior of individuals and institutions and, as a result, should be able to be loosened up over time. If improper admitting practices are corrected, it won't be necessary to continue with the same intensity of review over time. This frees up review resources to focus more on medical care evaluation studies. These are basically the same as medical audit studies that are being sponsored now by many hospital associations and national organizations. Their primary purpose is to continue to study quality of care and to improve practice patterns through continuing education. They involve the use of the classical feedback methodology, involving selection of a study area, the design of a study, collection of information, analysis of data, and development of recommendations which usually result in recommending continuing education for an entire hospital, a whole PSRO area, a service within a hospital, or a few individual practitioners. In addition, they often result in recommendations relating to administrative changes that might be needed within an institution.

A medical care evaluation study is not complete until all steps are taken, including plans for follow-up or restudy. Medical care evaluation studies are usually short-term in nature and quite focused. They take on one problem at a time. Therefore, problem selection is quite important since there aren't enough resources around to study all issues. MCE is performed on the basis of perceived need by the medical staffs of hospitals and by committees of PSROs, analysis of patterns and profiles of performance of hospitals and findings elicited from the concurrent review process itself. As I indicated before, much of the information collection side of medical care evaluation studies can be done by review coordinators during their concurrent review duties. In addition, hospitals utilizing abstract services can often find they are useful to help them collect information.

Finally, the last component, the pattern and profile analysis, is really one, as I indicated, which is used to monitor the whole system. It is also used to help focus the concurrent review process in identified areas for study in medical care evaluation studies. Pattern and profile analysis is simply a statistical analysis of aggregate data. It involves examining trends of a hospital's performance over time -- what changes are there in its admitting rates, lengths of stay, diagnostic mix, all the basic statistics having to do with health service utilization, and it also involves comparative analysis of hospitals against peer hospitals and PSROs against PSROs. It allows the PSRO to examine the impact of the concurrent review process on health services utilization. If I return for a second to the two principal objectives, assurance of quality and assurance of appropriate utilization, pattern and profile analysis is quite useful in determining whether or not utilization practices have in fact been improved.

The elaborate process of hospital assessment that a PSRO must perform allows each PSRO to set target objectives for each of its hospitals with respect to changes that it believes should be produced in admitting practices and lengths of stay. Pattern and profile analysis allows feedback to determine whether such objectives have been met. On a smaller scale, medical care evaluation studies allow the same sort of feedback with respect to assurance of quality. Through the studies themselves it's possible to determine whether deficiencies exist and to restudy whether they have been corrected as a result of medical education. So, you can see the whole concept of the hospital review system has inherent in it the feedback principle based on identifying problems, correcting them through education, restudying to see whether corrections have been achieved and whether they are being maintained.

I think it's obvious that this review system is a complex one. It is sophisticated and based on the latest available knowledge. It will obviously change over time and improve as much during this decade, if not more, as it has over the past. In addition, it will be subject to intense scrutiny to determine its usefulness in other areas such as long-term care institutions, be they skilled nursing facilities or public mental hospitals, and then in the ambulatory sector where some of these techniques will prove valuable and others won't. What I hope can be accomplished throughout the rest of the conference is an examination of the way

this hospital review process can be made to be most responsive to your concerns. Thank you.

ROLE OF THE NON-PHYSICIAN PRACTITIONER
IN PSRO MEDICAL CARE REVIEW

MRS. GERALDINE ELLIS, R.N.

Division of Peer Review
Bureau of Quality Assurance
Health Services Administration
Department of Health, Education, and Welfare

I would like to say that I welcome you most heartily, because I do think this is a real milestone in terms of getting the kind of input that we have asked in OPSR and BQA, to really specify, elaborate, and refine our present state of delineation namely, the role of the non-physician health care practitioner in the PSRO program.

I wish we could think of some kind of acronym that we could use to shorten that term, non-physician health care practitioner, which I think is very encompassing and covers this group that we are most concerned with today. But it gets to be a tongue twister, especially when you are trying to give any kind of presentation. So, if I stutter over it, please forgive me.

Dr. Simmons said that we don't have all the answers, and I think I would like to take that a bit further. I don't think that at the present time here at the federal level we have the resources to get all the answers, and I am not even sure we have all the questions yet. So, this is why we are so anxious to hear from you to get first the questions and then to begin to work on the answers.

I hope, however, that we have answered one question for you, because I am sure it's still a question among your many hundreds of colleagues out there in the real world, and that is yes, indeed, there is to be a role for the non-physician health care practitioner in PSRO review as it applies particularly to the care given to the beneficiaries of the Medicare, Medicaid, and Maternal and Child health care programs. Perhaps I also need to clarify the meaning of the term medical care review as it is stated on our agenda. We do, indeed, mean that term to encompass the full spectrum of health care provided to those beneficiaries; initially, those in institutions. I have been meeting with a number of groups of your various professions for the last seven or eight months, and I do sense a great deal of

skepticism about the law from people who feel that because non-physician groups were not identified by discipline in the legislation, there is really no input opportunity for them, no plan for the review of their care. I hope you all will be able to help us in changing that misconception, because it is a misconception. In reference to the materials that were sent to you, I just refer you to Section 1155B of the law and to Page 12 of the Senate Finance Report in your legislative history as points of reference that you might wish to use to help people really understand that they are to be a part of the PSRO review program.

Each of you, I know, received a copy of the manual prior to this meeting. I am sure, as you have had occasion to review it, you found many references to the non-physician health care practitioner's role. I won't burden you with chapter and section of the manual where this occurs, but I do feel compelled to review those guidelines that hopefully you will address during the course of our discussions today. For those of you who have heard this before from me, I apologize for having to review some of the same material. However, there are a number of you here who perhaps have not heard me speak, and this is simply to capsuleize what is spread over a number of different sections of the manual.

I think the most significant portion is included in Chapter 7, where it is specified that the PSRO will be expected to provide evidence over time that non-physician health care practitioners have become involved in certain activities within the PSRO framework, either at the PSRO level or at the institutional level where that institution has been delegated the review responsibility. And I would like to enumerate those areas. First is the development and modification on an ongoing basis of norms, criteria, and standards for the respective areas of practice, Second, the development of review mechanisms that will be used for peer assessment of the performance of non-physician health care practitioners. Third, the actual conduct of the review under the same umbrella of peer review mechanisms. Many of the programs that I hear about today are focusing first on an audit type review, but that's only one type of review. Another area is working with established continuing education programs to utilize the results of review in terms of education to correct deficiencies that might be uncovered in the process of peer review. And a very important aspect I think you all are interested in knowing about is that the manual does address the matter of joint physician and

non-physician health care practitioner review and development of criteria -- it should be reversed, development of criteria and review -- where their practice is joint. We are seeing some of this, though not a great deal, today. We hope that we will see greater involvement in a short span of time. We certainly hope that there will be non-physician participation with physicians on committees wherever it is appropriate. You probably also noticed that the proposals for conditional PSROs must include a plan for the involvement of the non-physician health care practitioner in review.

Obviously these guidelines are rather general; they are not nearly as specific as those guidelines Dr. Goran outlined in terms of admission certification, continued stay review, and medical care evaluation studies. There were reasons for this non-specificity. The first is that we really were not able to find models upon which we could base specific recommendations for how that review was to be accomplished. We did not feel that the state of the art had progressed that far within the majority of the non-physician health care practitioner groups. Maybe you can change that notion today. Certainly there were not enough staff on board in the Bureau of Quality Assurance who represented a large enough variety of the non-physician health care practitioner groups to come up with guidelines in any kind of specific fashion. Also, even if there were representatives from all the major non-physician health care practitioner groups, I doubt very much that the population of practitioners representing each group would want to have one individual or perhaps two develop the specific guidelines. In other words, they might not have credibility, and we do want the guidelines to have credibility. I think that's terribly important in gaining acceptance of the program.

The problem is that now the planning groups are getting into their jobs of developing a plan for a conditional PSRO, they are coming to us for assistance. How should the non-physicians become involved and what kind of review will they do? We don't have all the answers to that as yet. We are trying to get them. And we think that perhaps you will help us. Certainly we are obligated, if you read the legislation, to provide assistance to the local groups who are trying to get an effective quality assurance program under way. We feel very strongly that we must develop models, we must develop more specific directions, we must be able to go out and provide assistance to the local groups on an as-needed basis.

So, we need to know more about the state-of-the-art of quality assurance within your various professions. We know that some groups have made a very significant beginning in the area of quality assurance; others are just beginning to talk about it, maybe even haven't gotten beyond the talking stage. We are also anxious to reach non-physician health care practitioners at the local level. We recognize that they need basic education about PSRO and they need specific education about how they are going to fit into the PSRO effort. We know also that some of you and your organizations have really initiated a massive educational effort among your memberships. We know that other efforts are being planned although perhaps they have not started yet. We would like to know what is happening and what you are doing in the area of educating those in your profession.

It sounds like we are asking a lot from you, and I suppose you are going to wonder what we are doing. So, I guess I will try to redirect the discussion back to what our staff is doing at the present time and also to mention one or two items that we have envisioned for farther down the road. When I talk about our staff, I am referring specifically to the staff of the Division of Peer Review in BQA and even more specifically to those of us who are working as a team in relation to the non-physician health care involvement. As I tell you what we have done to date and what we are planning to do, perhaps you might make note of some suggestions that you would like to offer during the group discussions. Of course, we hope the group discussions will encompass more than what we are doing right at the moment.

First of all, I would like to say that we are trying to respond as promptly and as completely as we can to written and verbal inquiries about the PSRO program in general and about the involvement of non-physician health care practitioners. There is a lot of interest, we recognize, and we want to keep those flames of interest fanned, and encourage people, foster their involvement, and perhaps go back a step, foster their preparation to become ready for involvement. We have attempted to provide speakers for meetings of non-physician health care practitioners upon request and up until yesterday I was able to say we had responded to every such request. Yesterday was the first time I had to say we just did not have anyone available for the time we were asked to supply a participant for a national meeting. With the increasing rate of such requests we may find that we may have to say no to some simply because we

don't have anyone available at that particular time. It isn't that we would not want to be as responsive as we probably can. This brings to mind another thought in terms of something you might be able to do to help us. Many of you, I know, have made it a point to be very well informed about PSRO as it relates to non-physicians and perhaps you would like to let us know whether you would be able to do some speaking should there be such a need. Certainly with approximately a million and a half people that we recognize you, in essence, are representing, it's going to be hard for four or five or even six at this level to reach out to that large population.

We are working on developing a Division of Peer Review central file on information regarding quality assurance programs among the various non-physician groups. We see this as a means to assist others who are asking for samples of how things are done in peer review among a given discipline. If you have such knowledge of a program in existence, we would appreciate being put on the mailing list so we could receive such information and use it for broadening the educational effort. We are attempting also to prepare a brochure on the role of the non-physician health care practitioner in PSRO review. We are envisioning something like a question and answer brochure on PSRO but directed to the non-physician. We envision this to be a document that could be supplied to organizations to be used as hand-outs at professional meetings. Finally, we know we have to either expand the existing chapters of the manual as guidelines for the non-physician practitioner in review or develop a separate chapter. We have not decided which will be the final outcome, but it is something we know must happen. We think it may take as long as a year from now to have the specifics that we will need to accomplish that task.

Those are the major functions that we are performing right now. We probably will know about more things we need to do as a result of our meeting today. Again, I would like to say it is most gratifying to have you here. We appreciate your sustained interest and your enthusiasm for the program. And just from what I am hearing, where non-physician groups are getting involved in peer review programs and developing criteria for measuring care, they are finding it a very exciting experience. I think that if we can keep this going and make it flourish, we really will be able to make a significant impact on the quality of care.

DR. PEARL DUNKLEY

AMERICAN NURSES' ASSOCIATION

The American Nurses' Association is a professional organization representing 200,000 registered nurses with constituent associations in 50 states and three territories of the United States. Since its inception in 1896 the ANA has consistently demonstrated its concern for the development and implementation of professional standards through promoting state legislation to regulate the practice of nursing, developing standards for the preparation of individuals to enter the practice of nursing, and establishing a code of ethical conduct for practitioners as well as developing standards for nursing practice, standards for the organized delivery of nursing services.

As a result of more than a decade of diligent work by hundreds of nurses, in 1973 the American Nurses Association issued general standards of practice and specialized standards of practice in five areas, namely, medical-surgical nursing, maternal and child health nursing, psychiatric and mental health nursing, geriatric nursing, and community health nursing. To our knowledge, nursing is the only profession to have moved voluntarily beyond establishing a code of ethics to develop standards of practice. We would be glad to share these standards with any profession represented here and we will send you copies at your request.

The ANA has urged that immediate attention be given to amending PL 92-603 to provide for full participation of all health care disciplines in implementing a system of true peer review. While such amendments are under consideration, we urge provisions be made to assist all health care disciplines in developing appropriate norms and criteria to evaluate the quality of the care they render. Nurses are being utilized as coordinators in PSRO programs. They are gathering data used in the monitoring of physician performance. We do not view this as a legitimate involvement of nurses in the review of nursing practice. They are in effect assisting physicians in the review of medical practice, and we want to make that perfectly clear.

The efforts of the profession to engage in systematic review of the quality of care provided by individual nurses and groups of nurses began in the 1960's with the establishment of professional performance committees by the California

State Nurses Association. The early '70's saw an acceleration of the efforts in peer review with the publication of the standards of practice. We have developed guidelines for the establishment of peer review committees, and again these guidelines will be available to any profession that asks us for them. We have seen tremendous activities of a volunteer nature within the profession over the last five years. There has been a great deal of activity centered around the development and further specification of these standards of practice to render them amenable to measurement. All members of the association have received copies of these standards, and we estimate that a total of more than half a million are now in circulation. These standards speak to the practice of nursing. Activities to incorporate these standards into the regulation and statutes of boards of nursing as minimal standards for licensure are also under way. And in states like Vermont, Oregon, and Oklahoma action has been taken or is contemplated at this point in time. We believe that this is a significant aspect of the involvement of regulatory agencies in monitoring their continued competence of practitioners.

There is considerable effort underway in the development of norms and criteria relating to the measurement of outcomes of nursing intervention and the structure in which nursing care is given. We are seeing a testing out of a number of institutional review programs in many sites involving many institutions. ANA is devoting the major portion of its resources to coordinating and stimulating these efforts over the next two years in preparation for the full participation of nursing in interdisciplinary peer review, we hope, by 1976. We are working with JCAH in its activities to monitor nursing practices to bring them in line with what we believe to be professional standards. Under the leadership of state nurses associations, workshops and institutes are being held to help nurses develop the skills for developing norms and criteria and other evaluative and educational tools. ANA is trying to coordinate these efforts, and staff have been hired to provide direct assistance to nurses in their implementation of peer review systems. In July of this year ANA was awarded a contract for about a quarter of a million dollars by the Office of Professional Standards Review, and I will ask Mrs. Betty Erlandson, who is Project Director, to speak to the scope of this contract.

Our philosophy of peer review, as it relates to the individual nurse practitioner, is concerned with assisting this

practitioner in identifying areas of stress and weaknesses and giving leadership to the voluntary participation and continued learning activities, and we are hoping by so doing to alter the practice behaviors in a positive direction. Our newly initiated program of certification is based on documentation of performance in practice, and we are calling for evidence of peer review where this is possible.

MRS. BETTY ERLANDSON

AMERICAN NURSES' ASSOCIATION

The objectives of the contracted project are to develop screening criteria for the determination of quality, appropriateness, and necessity of nursing care rendered by nurses practicing in the five major clinical areas; to test the criteria in specific clinical settings; to develop guidelines for nursing involvement in PSRO; and to develop a document for the implementation of the methodology by groups of nurses participating in PSRO review systems at the local level. Also to publish and disseminate the criteria developed into a system and planning for their implementation at the local level.

At this point we have developed a technical advisory committee consisting of several experts in quality assurance and representatives of specialty organizations in nursing to advise us. The criteria sets will be developed by expert practitioners currently employed in the field. We have not as yet developed any criteria sets, but our focus now is in terms of concurrent and retrospective review of critical screening criteria.

MISS NANCY TIGAR

NATIONAL LEAGUE FOR NURSING

Unlike our colleagues from the American Nurses' Association, we represent organized nursing services, and I am a consultant in the Department of Home Health Agencies and Community Services of the National League for Nursing. We represent approximately 1,400 community agencies across the country.

I know that the PSRO is not the community. However, I would like to make one plea, and that plea is based on our experience with Medicare. Their regulations were brought forth and written for the hospital, the institutional setting, and then applied to the community-based programs. This was horrendous for us because certainly one setting is not like another. We make the plea that when you do consider community health you do not, in doing so, try to apply the standards that have been used in the institution to the community health setting.

Just to give you a brief idea of the kinds of activities we have been involved in with our agency members, we have a commitment from the National Organization of Public Health Nurses, founded in 1912, to provide tools to our agencies for their day-to-day operation in the area of service. We have been working diligently with utilization review and nursing audits with our agencies. We encourage all community health agencies to begin to incorporate these kinds of mechanisms into their day-to-day operations. Along with this, the National League for Nursing and the American Public Health Association since 1966 have co-sponsored an accreditation program for community nursing services.

Since the early 1970's we have been working with other national organizations who are represented here today to broaden this program so that it will become a program of accreditation of home health agencies and community nursing services. In this program, we use the standards that have been developed for the practitioner by our professional organization, the American Nurses' Association. We will also be incorporating the standards from other professional groups -- the American Physical Therapy Association, the American Dietetic Association, National Association of Social Workers, American Occupational Therapy Association -- where they have standards that should become part of this program.

I will now give the microphone to Miss Jean McKinley who will tell you some of the activities in organized nursing services in the hospital.

MISS JEAN MCKINLEY

NATIONAL LEAGUE FOR NURSING

Our Council, as we call it, is representative of about 200 hospitals and related institutional nursing services throughout all the United States, ranging from very large complexes, medical centers, to very small nursing homes. Our constituency has been very concerned over the past four years about quality assurance and PSROs to the point that each year our executive committee has identified this as a burning issue. Last year at our meeting in San Francisco we had Dr. Alan Nelson describe what was being done in Utah. This year in Philadelphia Mrs. Ellis will be coming to our annual meeting to discuss some of the current activity in PSRO. We do a great deal in continuing education workshops, and our focus again has been on assessment of care. We have plans for several workshops coming up next year on this general theme. In nursing audit we also have a series of workshops and are continuing this as one mechanism for evaluating care.

I might mention that our Council is a forum. Our voting members are hospital administrators and directors of nursing service. We again are not purely representative of individual members but rather agency members. We are hoping that today will be a great learning experience for us because we do have a mechanism and opportunity to exchange, to share information by using this form of dissemination to our members, which includes any members of the staff. We have many members who are neither nurses nor hospital administrators. We have licensed practical nurses, we have technicians, we have many non-physician health care practitioners in our membership. So, we do hope that although we are not in the process yet of too many active programs -- probably this office knows more than we do -- we do represent many, many hospitals and institutions across the country and are optimistic that we can get, at the decision level, some input in policy making in peer review that reflects the skill and the profession of these health-care practitioners.

MS. LOIS BERNBECK

AMERICAN ASSOCIATION OF NEPHROLOGY

NURSES AND TECHNICIANS

We are a fairly new organization. We have only been in existence for the last five years. We have an increasing membership of 1,600 nurses and technicians within the field and probably have a very broad spectrum around the country.

I would like to say that we would like to support ANA in that there must be delineation of the other health disciplines involved in PSRO. The necessity of including nephrology nurses and technicians comes from the fact that we are on the front lines when it comes to health care. With our expanding roles and our expanding responsibilities in many places, we are the primary health care practitioners that the patients will be involved with. Within some of our chronic settings, especially within our dialysis units, be it in the hospital, in the extended care units, or in satellites, the nurses and the technician may be the only health care practitioners that the patients see on a routine basis.

In order to come up with a quality of health care, our association very early took on the job of setting down standards of practice of care. We have developed standards of practice for both dialysis and transplantation, and they are available for distribution. I would also like to note that these standards of practice have been used not only by our nurses and technicians but by many of our physician colleagues in setting standards within their units. We have also undertaken the development of standards of peritoneal dialysis which we hope will be available within the year and we are also embarking on setting standards of care of both conservative management and acute care. Any of the organizations here represented can write to our headquarters, and we will send copies of our standards out to you.

In addition, in order to help implement the standards of care, we have from our inception had programs on a national level. We also have divided our association into five regions and, starting this year, all five regions are having annual educational programs. Our chapters are set up with the primary idea of continuing education, and this is mandatory in order for them to be a bona fide chapter of our association. We have organized a board to help bring up the level of

continuing education at national, regional, and chapter levels. In order to also help establish some base-line quality care, we have gone into the process of certification at the entry level of care, and hopefully within a year we will have a certification process.

AMERICAN SOCIETY OF HOSPITAL PHARMACISTS

The American Society of Hospital Pharmacists appreciates the opportunity to participate in this non-physician health care practitioner conference on peer review and PSROs. As we understand it, the purpose of this conference is to explore the current status of peer review of non-physician health care practitioners and the care provided by their disciplines. We see the PSRO as reviewing the necessity of service, the appropriateness of the facility, and the quality of the care.

The ASHP and its 11,000 members generally has little input into the first two aspects. However, the third, the quality of care, provides us a significant opportunity for involvement of hospital pharmacists in PSRO activities. My brief presentation will focus both in the ASHP role as a national organization and on the activities of our individual members as they relate to on-going programs in hospitals and related institutions such as intermediate care and skilled nursing facilities.

At the national level the ASHP over the years has developed many standards and operating guidelines for the practice of hospital pharmacy, several of which were formulated in cooperation with and approved by other organizations such as the American Hospital Association and the American Pharmaceutical Association. Of significance is the statement on the abilities required of the hospital pharmacists. Most of these are structure and process oriented, although improved drug therapy in terms of patient outcomes has always been the ultimate goal. The society has also had significant input into the standards for pharmaceutical services of the Joint Commission on the Accreditation of Hospitals. Its active continuing education program includes a milieu of clinical meetings which last year attracted 2,500 practitioners and featured a general session on quality assurance and PSROs. Representatives of the American Medical Association and American Hospital Association, consumers and pharmacy leaders presented their views. The Society's pharmacy residency accreditation programs in hospitals as well as its publications activities, including the American Journal of Hospital Pharmacy and the American Hospital Formulary Service, are indicative of our interest in elevating the standards of practice on the part of the hospital

pharmacists.

Rational drug therapy to us has been defined as the provision of the right drug in the right dose by the right route at the right time with due consideration of economic implications. As members of the hospital's Pharmacy and Therapeutics Committee, a standing committee of the hospital medical staff, pharmacists have traditionally played a major role in all activities aimed at achieving these objectives. These activities include system aspects of drug distribution and educational and service programs such as newsletters and drug information services. However, they also include, albeit more recently in the evolution of pharmacy, clinically oriented activities such as drug history taking, maintenance of patient drug profiles, drug utilization review mechanisms, drug surveillance and monitoring, and patient education, including discharge consultations to foster patient compliance with prescribed drug regimens.

Since drug therapy in hospitals involves physicians, nurses, and pharmacists, there is a significant overlap among the drug-related responsibilities of these disciplines. The increasing clinical involvement of pharmacists accentuates the difficulty in identifying the boundaries between these disciplines as they relate to drug therapy. Therefore, in addition to developing standards for the more traditional roles of pharmacists in drug dispensing and distribution, similar standards must be developed for existing and continually emerging clinical roles. Quoting from Section 709.18 of the PSRO Manual, "For those conditions in which care is often provided by physician and non-physician practitioner, the norms, criteria, and standards should be jointly developed." We interpret this as a call of a cooperative effort in aspects of patient care, including drug therapy, in which there is an interdisciplinary involvement and responsibility.

Care provided by pharmacists in many hospitals includes care which in the past had been the traditional responsibility of physicians. This is a fact of life. The clinical role of the pharmacist is with us and is no longer just a part of a dream or a grand scheme fostered by pharmacy practitioners or their national organization. The Board of Directors of the ASHP recently approved the development of a quality assurance program for pharmaceutical services in hospitals. Standards and criteria for this program are now being developed, and they will cover all aspects of the pharmacist's

function in the institutional setting. Since PSROs, at least in the beginning, will address themselves to the care of institutionalized patients, we see this program as distinctly related to the non-physician peer review aspects of PSROs. At the individual hospital level, many pharmacy practitioners, in cooperation with nurses and physicians, are developing outcome criteria for any therapy that involves prospective, current, and retrospective activities related to drugs, ranging from drug histories that prevent unneeded and unwarranted prescribing to discharge drug therapy plans to patients in the subsequent educational programs. Other activities such as adverse drug reaction monitoring and reporting as well as ongoing evaluation of patients' status that are using drugs is currently in the process.

We believe now is the time for norms and criteria to be developed at the national level. The ASHP, its 41 state chapters, and its membership stand ready to assist the PSRO movement at the national, state, and local levels in the identification of elements which constitute contemporary pharmacy practice in the development of norms and criteria for good pharmaceutical practice and in performance, assessment, and testing of existing and emerging functions of pharmacists. We are already committed on this path and hope our efforts can be a cooperative approach with other professional associations outside pharmacy as well as with government agencies which are charged with the development and enforcing of the approved standards.

DR. RICHARD PENNA

AMERICAN PHARMACEUTICAL ASSOCIATION

If there is one thing that the PSRO movement has done for pharmacists, I think it is to focus our attention on the word "standards." I believe a great deal of attention must be focused on that word because it means many things to many people. For pharmacists, standards can be interpreted to mean two different things. One, standards of competence for the individual practitioner; and, secondly, standards of performance for the service which is delivered. And we have approached both of these functions somewhat differently.

For example, in terms of standards of competence for the individual pharmacist, we are in the process of completing a joint effort with the American Association of Colleges of Pharmacy to develop or consider the entire issue of continuing competence of pharmacy practitioners, which relates to the education, the training, the motivation, and the performance of pharmacists in their everyday tasks. And this effort will probably result in a national commission on pharmacy practice standards which hopefully will then result in standards of competency for the individual pharmacy practitioner.

With regard to standards of services provided by the pharmacist, this must relate, we believe, to the environment in which care is delivered. Obviously service differs somewhat, if you are delivering care in the community environment or in an acute care hospital or in a long-term care facility or a health maintenance organization or what environment you are thinking about. And for that reason we are considering the various standards for care in terms of these environments. You have heard from the American Society of Hospital Pharmacists, and they are doing an excellent job in developing the necessary criteria and standards for care delivery in the acute-care hospital.

With regard to the long-term care facility, we cooperated with the Department of Health, Education, and Welfare in developing the conditions for participation for pharmaceutical services for skilled nursing facilities under Medicare. We believe these are fairly broad ranging and rather specific in terms of the standards for care which is provided. We are currently working with the Department through a contract to acquaint pharmacists throughout the country with these

standards, if you will, or conditions for participation. We are going further and showing the pharmacist how he can involve himself more completely with these standards -- for example, when it comes to monitoring drug therapy of patients served by the long-term care facility.

With regard to the health maintenance organization, and this is looking down the road somewhat but assuming that PSROs will become involved with HMO sooner or later, we have completed a project of developing a drug use review manual which is appropriate for drug utilization review in organized ambulatory health care facilities such as a health maintenance organization. We are currently in the process of Phase 2 of that project in which we are tying the drug use review process with diagnosis, and that will be completed in June of this year. We look for this to be a very significant step toward providing a realistic process for developing drug utilization review systems in an ambulatory care environment.

This gets us into an area which has potential problems, because it does involve a matter of inter-professional relationships and it relates to the matter of who reviews who. The PSRO law is quite specific in that physicians shall review physician activities. But in the example given by the Senate Finance Committee, I believe, they said, using an example of physical therapy, that physicians would determine whether or not physical therapy services should be ordered, but it's up to the physical therapist to look at the quality of those services. With regard to drugs, if you are going to take the same approach, physicians would determine whether or not a particular drug should have been ordered, but it is up to the pharmacists to determine the quality of the services under which those drugs were provided.

Looking at the drug utilization review procedure which does address itself to how physicians prescribe and what they prescribe, in my mind and in the mind of our association and I think in talking with other people, this is a fairly common concept -- you can't look at drug utilization review outside inter-disciplinary activity. It must be a common function of pharmacists and physicians and nurses and other prescribers, dentists and doctors, working together rather than just a unilateral activity of physicians. And we are addressing ourselves to that activity through a number of proposals which we are developing for in-house use over the next year.

MR. CHAUNCEY A. ALEXANDER

NATIONAL ASSOCIATION OF SOCIAL WORKERS

I want to congratulate the PSRO staff on the progress that has been made in the last two years and certainly their clear, succinct review of this program to date. It is very encouraging to get that kind of clarity. I do hope that because of what we consider to be the importance of this program the federal staff will be more comfortable, less apologetic about their role in the execution of the program, because we feel that this is a step that has been long overdue as a program, and the more aggressive leadership that can be given in the PSRO program, the better.

The NASW represents the social work profession with our 60,000 members who are in 140 chapters across the country, and over a third of our members are in the health care system at various points. We have been long concerned, however, that the whole problem of continuity of care, of entry and exit and re-entry into the present medical care system, has not had the kind of help for patients that is necessary. We have also been concerned that less than 42 per cent of the hospitals have social service departments although that is considered to be a necessary requirement of the standards of accreditation for the American Hospital Association and the Joint Commission on Accreditation of Hospitals.

Social workers are related to this problem in many different ways because we are in so many different aspects of where people get health care provided for them. For example, at the present time, although it is not known very well, social workers provide over half of the mental health treatment services in this country and are increasingly providing health care services through agencies and private practice and a variety of other new fields where health care is being delivered. The present system of health care has had social work participation, for example, in the Social Security programs, Maternal and Child Health Services, federal health benefits, private insurance programs, in CHAMPUS, in Medicare and in Medicaid, so that there is a consistent participation.

We have always been concerned with the limitations on the utilization of the system, particularly the entry into the system, the patient's care in that system and how the system is utilized, and then certainly in discharge planning and the use of community resources, which is where social workers

have tended to be particularly concerned. We also feel that the PSRO will have a decided impact, if it's adequately implemented, on the whole relationship of the patient to the community as well as to the immediate milieu of the family. We are concerned with such things as the impact of family relationships on heart disorders or the inadequate services that exist in connection with stroke care in this country. Social workers see this most because of the fact that patients leave and then must deal with their environment on the outside as a result of that care and must use community agencies.

We have been involved in one aspect or another of quality assurance for a long time as a profession. We have an established code of ethics which is a requirement of practice of our members, and we adjudicate grievances that are brought against our members of any unethical practice, and we discipline our members on that score.

We also have a national advanced quality control program that we have instituted of advanced practice certification which is a nationwide testing program at a self-regulated practice level in the social work profession. And, third, we are now engaged in peer review experiments in a number of our chapters, although we are not greatly enthusiastic about the concept of peer review, having worked with the medical profession. We are not sure that that's the road to go, particularly in a profession which has responsibility or deals with a lot of community agencies and thus is related to community services.

We have worked and developed standards in conjunction with the American Hospital Association and the Joint Commission on Accreditation of Hospitals as well as with other professions, although those have been particularly in the mental health field. We have also developed a differential classification system for social welfare manpower which we think will have an important impact on the quality of service delivered, and that is now being promoted throughout all of the agencies and the various hospital services in order to differentiate the levels of practice within the social work profession and the quality and levels of training needed to implement that practice. We have an active licensing development program and now have 13 states in which there is licensing using our model statutes of licensing, and we have bills before 27 state legislatures right now to develop licensing in that many states.

One of the important aspects of this, of course, has been referenced in continuing education. We have a long history of continuing education, particularly in the medical and psychiatric aspects of health care, having for some 15 or 20 years run regional institutes and national symposia on psychiatric care for training purposes. We are now engaged in a long-term project of training some 4,200 designees and social work consultants in long-term care facilities. Our interest is to attempt to raise the level of practice and provide better service.

We also feel that it's extremely important to work with the other professions, and we have worked closely with the American Nursing Association and a number of others. We were one of the original organizers here in Washington of the Coalition of Independent Health Professions, which I mention because it was organized about four years ago as a result of the concern of our professions for the development of quality assurance and for the responsibility of the health professions to develop their own standards. That Coalition, I think, has contributed to developments of this nature.

We certainly want to collaborate and cooperate in a number of ways. We have social workers now active in some of the existing PSROs where they have been accepted. We consider that it would be difficult to evaluate medical practitioners without evaluating the way in which the medical practitioner uses services that are necessary and particularly service-related connections between hospitals and community agencies in order to provide adequate service. We feel that there has to be a social work in-put into peer review and professional standards.

MR. RALPH NEMIR

AMERICAN PSYCHOLOGICAL ASSOCIATION

The American Psychological Association represents 38,500 psychologists, about half of whom are involved in the delivery of health care services. Psychologists are licensed in 47 states and the District of Columbia. The American Psychological Association has a code of ethics which was adopted 20 years ago and is substantially contained in all 48 licensing acts in the country.

We are presently in the process of developing a system of peer review within our own profession, using the state association of psychologists as a focal point. We presently have, plus or minus, 33 active and operating PSRCs, as we call them, and they are all operating under the guidelines promulgated by the Committee of Professional Standards Review of the APA. We also have adopted, as recently as Monday of this week at the annual convention of the APA in New Orleans, a set of standards for psychological practice. This is a very significant development which we believe will dovetail very closely with the efforts relative to peer review. We are also involved in the development and evaluation of continuing education mechanisms within the profession. As soon as the end of this month, we will convene the first of a series of conferences to develop a set of model criteria for the review of mental health services delivered by psychologists.

We are especially appreciative of the opportunity to be here today in that we have several interests which most likely are shared by the other groups represented. In the development of review criteria, we would appreciate very much the expertise and the financial help that might be available to us through your office. We are extremely interested in the development of joint criteria relative to patient outcome in the case of mental health services. This will require coordination by the Department of the efforts of the APA and other professional organizations of mental health practitioners, including the medical practitioners.

We also seek to provide input into the development of the mechanism whereby the non-physician health care practitioner will participate in a true peer review process at the local PSRO level. We are aware of your sincere efforts to work with us in developing that. We hope that we can make a significant contribution in that regard.

MR. JOHN SMITH

AMERICAN SOCIETY FOR MEDICAL TECHNOLOGY

The American Society for Medical Technology is a national voluntary professional association of over 20,000 medical laboratory personnel. In 1972 we adopted our national minimum standards for clinical laboratories, and these standards are sections that deal with quality control for the clinical laboratory, personnel qualifications, and standards for continuing education. This paper is available for any of you who wish to review it.

ASMT views the primary role of the non-physician in the PSRO effort as directed to quality assurance programs which are developed and refined as part of the peer review process within the medical laboratory. Toward this end, ASMT has developed a strategy which revolves around three specific features. The first feature is that I have appointed a national peer review task force charged with the responsibility of the development of criteria and standards for laboratory procedures and conditions. Secondly, in collaboration with other appropriate professional organizations, ASMT is exploring cooperative peer review activities. Contact has been initiated with physician laboratory professional organizations in an effort to develop areas where cooperation is possible. To this end for our own association we are engaged in an extensive education process to educate the leaders of our national association and our affiliates in each of the states. Thirdly, state and local constituent ASMT societies are organizing to work in an advisory capacity with developing PSROs. ASMT is directing periodic information on the PSRO program to its state societies and has initiated direct contact between our state groups and the HEW regional personnel who are acting as the focal point for PSROs within each region.

I want to thank you for inviting us to participate in the conference today.

MR. WILLIAM K. YOUNG

AMERICAN MEDICAL TECHNOLOGISTS

The American Medical Technology Association has a registry of over 11,000 members, and at this time it has not established or participated in any peer review system. It has been primarily concerned with continuing education of laboratory personnel at the national, state, and local levels. It looks forward to becoming a non-physician participant in the PSRO program.

MR. RICHARD PAUL

AMERICAN ASSOCIATION OF BIOANALYSTS

I would like to point out that the American Association of Bioanalysts is primarily an organization of laboratory directors who operate laboratories outside of hospitals. We have a few members in hospitals, but most are operating independent laboratories. Our organization began right after World War II. Our first effort in coming up with a quality control mechanism was, of course, our code of ethics which defined the responsibilities of the bioanalyst to the patient, the physician, the public, and the laboratory colleagues. And, as an example of the importance we placed on such relationships, I might point out that in our Pennsylvania chapter we impeached a president for unethical conduct some 20 years before Watergate. A second activity for elevating standards was our efficiency testing activity which we started in 1949. Under this system, identical specimens were sent to all members of the association for analysis, and then the results were tabulated. This showed some tests to be performed very well and some to be performed not so well. And this led to our proficiency testing service, which is now very widely used.

When Medicare became a reality, only a handful of states had any regulation of laboratories and even some of these states did not offer proficiency testing. We therefore proposed that they use our system, and it is now being accepted by 26 states and Medicare and also provides the internists group in California with their quality control system. I might just take a minute to show you what this set-up is. The laboratory who subscribes to this service gets specimens four times a year. And, depending on the type of work they do, they can subscribe to various portions of it or all of it, and it includes chemistry, microbiology, hematology, immuno-hematology, serology, and rubella testing. Four times a year specimens are sent to the laboratories; they all get identical specimens. They analyze them and return them, and a computer sets it up. The computer calculates the mean for all laboratories in the country, the standard deviation, the code of variation, two standard deviations which is the acceptable range; and thus every laboratory can compare its performance with laboratories throughout the country. This has been, as I say, accepted by Medicare, and we hope in the near future to have it also accepted for the interstate laboratories.

After we got that going, we realized we had to have an educational service going with it. So, we set up what is known as the Board of Scientific Advisors to guide this proficiency testing and to send commentary along with it. This board is composed of university professors, consultants, laboratory directors, and a pathologist; and in addition to advising the proficiency testing service on what is appropriate, they publish a monthly bulletin called the Test of the Month. And this Test of the Month picks out some particular test and, rather than spending its time on the actual performance of a test which is in any laboratory manual, it gives a discussion of when the test is useful and when it's not useful and what problems ought to be titled in doing it.

This is the sort of thing I think will be particularly effective in peer review on cutting down the use of unusual or unnecessary tests and also, in conference with the physician, showing them which tests will be more beneficial to the patient and which will give more relevant information. That, then, is sent to everybody who is involved in our proficiency testing set-up. And in fact it has been so popular, that the past issues are now available in bound form as a reference volume.

A fourth activity was to establish the American Board of Bioanalysis which now functions as an autonomous board and passes on the qualifications of laboratory directors. When originally set up, of course, they had a grandfathering, and that time has now expired, so that the doctoral degree is one of the qualifications for certification as a diplomat of the Board of Bioanalysis. And our board is now also active in certifying laboratory supervisors.

A fifth activity we are working on which hasn't been fully developed yet is to establish curricula leading to a Ph.D. degree in bioanalysis at various universities. We hope to get several in various parts of the country. Perhaps it hasn't occurred to you, but in the regulations for biomedical laboratories under Medicare and Interstate, they are requiring doctoral degrees in biology and chemistry. The Ph.D. degree in biology and chemistry, as presently constituted, is essentially a research degree, but it is not a research position. In other words, they are requiring a square peg in a round hole, and there is no school really which offers such a curriculum at the present time.

So, we are hoping in the near future -- I am working principally now with some in California -- to get established universities to include a curriculum which would be more apropos to the direction of a bioanalytical laboratory. We hope that we have gained something from these activities which we will then be enabled to incorporate into the PSRO set-up.

MR. MARVIN FRANCE

THE INTERNATIONAL SOCIETY FOR

CLINICAL LABORATORY TECHNOLOGY

The International Society for Clinical Laboratory Technology is an association of medical laboratory personnel composed of medical technologists and medical laboratory technicians, numbering some 4,000. The Association has been in existence since 1962. The organization maintains a registry of both technologists and technicians and also an autonomous agency which accredits the educational programs.

ISCLT has not gone into peer review to any great extent as yet. We have been primarily involved in continuing education at state, local, district, and national levels; publication of technical materials for dissemination to our members; and along with our continuing education program, we maintain records of the members' continuing education. We make available to our members a personal performance evaluation program, which is a proficiency testing program, so that the individual can determine his own personal performance and gauge it against norms.

We do look forward to participating as a non-physician practitioner in peer review. We are already participating in some of the provisional PSROs which have been set up.

MR. MICHAEL JOUETT

AMERICAN ASSOCIATION FOR RESPIRATORY THERAPY

I want to express my appreciation for being allowed to participate in this conference and attempt to represent the view of the respiratory therapists. Peer review activities in respiratory therapy are pretty much the same as in many other of the organizations we have heard from this morning. Basically there are two phases. There is a formal phase in our credentialing system, and a less formal clinical peer review phase which I will discuss a little bit later.

Our credentialing system is our strongest peer review activity at the present. The credentialing system is comprised of the National Board for Respiratory Therapy, a newly formed body centered in West Wood, Kansas. It's an autonomous body which is sponsored by the American Association for Respiratory Therapy, the American Thoracic Society, the American College of Chest Physicians, and the American Society of Anesthesiologists. The board administers two credentialing examinations -- the certification exams and the registering exams. The Board of Trustees of the National Board is comprised of both registered and certified respiratory therapist and physicians. Bilateral and uniform input into the whole examination and credentialing process on both the physician and therapist levels is assured by this association. The National Board is currently exploring the alternatives of requiring either continuing education or recredentialing as maintenance for the credential in the future. As funded by a recent HRA grant, proficiency examinations for two levels of respiratory therapist were recently developed, and they are under consideration and test as being incorporated into the credentialing system at this time.

To speak more closely to the points that are going to be discussed this afternoon, certain activities, as delineated in the PSRO Program Manual, which define the process of peer review insofar as PSRO is concerned, do exist in the respiratory profession although in a much less formal and structured state. These, as I see them, are the development of criteria and standards and the review processes in relationship to criteria and standards and then the subsequent evaluation and feedback into performance of respiratory therapy. The development of criteria and

standards takes place primarily in those areas where approved respiratory therapy schools exist. These schools are usually centered in a college or a university, and are affiliated with hospitals in that area in which the students take their clinical training. The criteria and standards as they are developed then come as an expression of the curriculum design for that school. The input into that curriculum design of course is provided by an advisory committee. In addition, the education committee of the AART is now developing what is going to be termed a therapist performance index, which will be an index against which performances of respiratory therapists can be measured and evaluated in behavioral terms. And this, it seems to me, would be particularly applicable to a PSRO criteria and development system.

The establishment of norms in respiratory therapy has been largely lacking. There was a recent conference in Sugarloaf entitled "The Conference on the Scientific Basis for Respiratory Therapy," sponsored by the American Thoracic Society. The lack of norms relating to the use of respiratory therapy techniques and the outcomes as the result of those interventions was one of the subjects for discussion. Although the conference concerned itself with respiratory therapy as it applies to patients with chronic pulmonary disease, the problems of evaluation of respiratory therapy techniques in patients with acute pulmonary disorders are similar. Meaningful statistical analysis of the effects or outcomes of respiratory therapy in both classes of patients is difficult and probably impossible in certain instances, because of the inability for the most part to isolate and directly measure such effects. However, it's probable that not all that could be done in this area is being done, and that was one of the resolutions taken up by The Conference on the Scientific Basis for Respiratory Therapy. The review and evaluation portion of the process of peer review is a very, very informal clinical activity on the part of both physicians and respiratory therapists. Using the term peer review in this instance may be stretching the semantics of the point a little bit. For the most part, it's a concurrent process with the clinical application of therapeutic techniques. In terms of the language of the PSRO program manual, respiratory therapy may be best described as care provided jointly by physicians and non-physician health care practitioners, and as such this clinical review is carried out jointly.

In his or her relationship to the physician, the highly trained respiratory therapist has been described as a Class B physician's assistant. He does not possess a broad general knowledge in areas of medicine such as a Class A physician assistant but does possess considerable knowledge and skill in the narrow areas of respiratory therapy that exceed that of the Class A physician's assistant and indeed most physicians. The dissemination of evaluation and the collection of data to date is largely unstructured insofar as the respiratory profession goes. It is carried out by departments of cardio-pulmonary disease at most medical centers, and is disseminated largely through the current literature.

MRS. ISABELLE HALLAHAN

AMERICAN DIETETIC ASSOCIATION

We welcome this opportunity to be with you this morning. We are going to divide our time. I have agreed with Dr. Winterfeldt that I will talk about the association, where we fit in and where we think we are going as an association of dietitians in the country. And Dr. Winterfeldt will pick up on the specifics on PSROs that relate to the American Dietetic Association.

We are about 26,000 members and were founded in 1917 by a handful of less than fifty. I believe the exact number was somewhere around thirty who founded the organization in Cleveland in 1917. Our membership from the very beginning was based on education, and requirements for membership in the association are still based on education and clinical experience. We had as the first requirement in 1932 that every member must have the baccalaureate degree, and I am told that that was real trauma at that time. In 1969 we moved to professional registration, and this was voluntary on the part of the members. So, since 1969 we have used the designation RD, Registered Dietitian. Over 90 per cent of our members chose to become registered at that time. Since that time there is an examination which is administered twice a year. We do have a standing committee in the association on professional registration who review the requirements for registration, make recommendations to the executive board, and also oversee the administration of the examination.

We have just completed our first five-year period. Part of the process is continuing education, and there is the requirement that there must be 75 hours of continuing education in every five-year period. This is subject to review, and I am sure within the next five years we are going to have some new recommendations from our committee. We have felt this has been a boon to the profession. Programs at both the district and the state level have improved as the result of this, and our members have been eager to fulfill this requirement.

In 1970 we took a look at ourselves for the seventies, and we had a task force of members meet in the first week of January 1970 to see where we were going in this decade. At that meeting it was announced that through a private grant

from Kellogg we were to have a study commission take a look at dietitians and the practice of dietetics. It was a question of having the foresight on the part of our leaders and also bravery on the part of the members to have an objective view of the practice of the profession. Out of this study came several recommendations. One was that we consider expanding our membership to include all of those who served on the nutritional care team. Since the requirements for membership were written into the constitution, it took an amendment, and those of you who are in professional association work know that this is not easy to come by. But just last month, the fifteenth of August, we had completed a full membership vote on the expansion of membership in the association and it was positive across the board. So, as of 1975, we will be taking into membership those who are at the technical level. There are other classes of membership, but I think that is the one that is of most interest to you today, the person with two years and an associate degree. This, of course, increases our responsibility for education in the profession.

In our constitution and in our code of ethics we have a commitment to education and public health and welfare. We use our journal, of course -- many of you are familiar with that -- as an educational medium and for continuing education of all our members. We have a circulation of over 30,000 with our journal every month. We are of course committed to this whole idea of education. The American Dietetic Association sets the pace for education in the profession, both at the college and the university level, and entrance requirements and continuing practice in the field.

We are dependent, as are all organizations like ours, on the role of the volunteer. A year ago it was my happy appointment to ask Dr. Winterfeldt if she would take on the committee on PSRO for the American Dietetic Association.

DR. ESTHER WINTERFELDT

AMERICAN DIETETIC ASSOCIATION

Within the American Dietetic Association we have long worked with a code of ethics, although we have not refined this to the extent of having a process to review practice as a result of it. The impetus, I think, for our going into the field of peer review and then further on into the PSRO function has come through concerns within states. What we would look at are ethical practices and procedures. I suppose we are not unique among professions in having a few members who sometimes resort to other than 100 per cent ethical practices and procedures.

In any event, the impetus has come. Our national committee has been appointed, as Mrs. Hallahan mentioned, and the committee has now determined that our primary function is to first develop the standards of practice and, according to the definitions in the Manual that we have just received, I really think these are criteria for practice, and then standards follow those. This is what we are developing at the present. We have further determined that we will develop these for the professional areas of practice within dietetics. We have already a structure that follows four areas of practice. We plan to develop our standards following these four main areas, realizing that there are many other actual employment areas that fall within each of these four areas of professional practice, so to speak. Insofar as state activities have been concerned, our model one is the Utah program. Dietitians in the State of Utah are participating in UPRO and we feel quite proud that we have this to use for our model.

We feel that we are fortunate to be able to hear what everyone else is doing and find out how we stack up in comparison. We would very much like to echo others' comments in regard to help expected from the national PSRO office as being primarily that of expertise in developing standards and further quality review mechanisms and financial assistance.

MR. WARD KELLER

AMERICAN SOCIETY OF RADIOLOGIC TECHNOLOGISTS

Though we have interests in PSRO, we are not involved in peer review activities at this time. Hopefully, we will be in the near future.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

I will omit the extensive standards regarding education and registration of occupational therapists and certified OTs, and will focus instead on the programs that are more patient-oriented and particularly the programs that we have had in the last year regarding PSRO and the peer review that is closely related to PSRO.

The first thing that we attempted to do was to undertake an educational program on a shoestring. We made reference materials available to all the membership at cost. This was an annotated bibliography regarding peer review, a definition of terms -- since we found there was great confusion between what are criteria and what are standards and what is a norm -- and we selected reprints and made all these available in a PSRO packet to our membership. We also started monthly articles on PSRO and peer review in our OTA newspaper and journal.

There were two workshops given in our last mid-year meetings, and the attendance was very good, indicating a need for more of this sort of thing. The interest is high, and many people are asking how to develop the kind of criteria that PSROs are going to be using. We have standards for the practice of occupational therapy, but they are not the specific sort of standards that the PSRO is going to be requiring. And to answer this need, we are having a criteria development workshop in October. It's given by Dr. Clem Brown. It is a two-day workshop, and we have selected people from various states to attend, and then they will be responsible for going back and presenting this information in their own state.

We also sent out a questionnaire in February to the state OT associations to ascertain what they were doing regarding peer review and to tell us their needs. They asked us for models of peer review and they also asked us to provide the national level criteria. Our plan is to try to meet these needs in the future.

We do have as part of our continuing certification program the development of criteria. Although they will be useful, they are not the specific sort of screening criteria that PSRO is going to need. So, we are in the process now of trying to present a resolution that will be accepted by the

delegate assembly to give us some funds to start work on the screening criteria. That is sort of a quick sweep of what we are doing.

AMERICAN PHYSICAL THERAPY ASSOCIATION

I have before me about a 12-page history of the involvement of our association in quality assessment activities. Included in that is a description of various existing programs of our association, including educational standards, licensure, provider qualifications, competency examinations, formalized continuing education programs, standards for ethical conduct, and of course professional practice standards. I will quote one element from this history that we have pulled together. By the way, it was illuminating to do this history, and it might be worthwhile for others to consider making this effort, of reconstructing what you have done. In general, we found that we had done a lot more than we realized.

In our association's June 1971 position paper on priorities in the health care system, we advocated certain priorities which would promote the right of all persons to have access to an equal availability of high-quality health care services. And one of these priorities was, and is, "The Health care system should be accountable to the public and should include effective mechanisms for peer review, multi-disciplinary review, and consumer participation in policy and audit of the system." And then we went on to inadvertently describe PSRO as it has emerged.

However, about five years before that time, we sensed the need and felt the responsibility to be involved in some system of quality assurance as the role of third-party payers expanded. At that time, a series of "cookbook" guidelines were generated. More importantly, standards of practice were formalized and a system of voluntary peer review was created. This package then was offered to the third-party payers of this country, all of the fiscal intermediaries, and all the state agencies, and all of this was greeted essentially by them with a hearty yawn. However, undaunted, we didn't throw all this away and now perhaps through PSRO what we were attempting to do five years ago now has some impetus to make it move. I have essentially buried or tried to bury, all the cookbooks. We have refined the standards of practice and of service. We still have a system of voluntary peer review ready to move in whatever direction society can best use it.

So, in essence, I would say that we are ready when you are.

DR. RICHARD CURLEE

AMERICAN SPEECH AND HEARING ASSOCIATION

I want to summarize just briefly some of the highlights of our association and our profession's evolution toward an accountability program for speech pathology and audiology services. With the organization's beginning, of course, like most organizations, we had a code of ethics, and we have an ethical practice board that adjudicates complaints against some of our members in terms of the code of ethics.

Later on in our growth, we developed a certification program and that certification program has continued to be upgraded throughout the years. The standards contained in certification for speech pathologists and audiologists are recognized by Medicare, Medicaid, and other government agencies for payment. It includes academic experience, practicum experience, a year's internship, and a national examination which the association helped develop and which is currently administered through the National Testing Service. We accredit clinical service programs through our professional services board, which includes a site visit. During the site visit the clinics that are being accredited are to have an appropriate mechanism for determining that the services each clinic provides are monitored appropriately and effectively at that clinic.

In terms of PSROs, the association recognized January a year and a half ago the import of this for the health professions, and they assigned the responsibility of monitoring PSRO development to the Office of Research and Scientific Affairs. Since that time our major activities have been in the area of information gathering and dissemination, and that has included visits on the part of our national office staff to computer-assisted medical foundations who are using a review system through the use of computers. It has also included attendance at both national and regional meetings on PSROs. We conducted our own national meetings among clinic directors on PSROs, have published information as we have received it to our members through a regular publication of the association, and have conducted special mailings.

We have encouraged state speech and hearing associations to form committees of professional standards review within each state to coordinate efforts of speech pathologists and audiologists in each state, and we are now in the process

of setting up a PSRO liaison representative among our members that ultimately will exist not only in each state but within each PSRO area, so that we can help facilitate the communication of problems and programs that are being developed for speech pathologists and audiologists at each PSRO unit throughout this country. We hope to have an organizing meeting of all of the liaison representatives at our national convention this November in Las Vegas.

The Association is committed to the concept of professional review of services based on patient outcomes as well as process review. They have organized a task force to develop a master plan for the association's involvement in the creation of a review system that would be compatible with PSROs. We are meeting with that task force and are attempting to look at the kinds of criteria one needs to develop to determine when you should initiate treatment and when you should terminate treatment and how outcomes are related to the various communication impairments with which we deal.

We appreciate the interest of your office in inviting us here today and allowing us to participate at this meeting, and we seek your support and your expert advice as we try to wrestle with the problems of establishing an effective review system for our profession.

MR. JOHN S. PRICKETT, JR.

NATIONAL REHABILITATION ASSOCIATION

We appreciate the opportunity of meeting with you. First of all, I might tell you just a little bit about the National Rehabilitation Association. It's not a professional organization as such. It has lots of professionals in it. It also has consumers and individuals who are interested in the handicapped of this nation. It was organized in 1925 and is 49 years old.

The core of our membership back in earlier days was that of those individuals who worked in the state/federal program of vocational rehabilitation. And in 1943 the Vocational Rehabilitation Act, Public Law 113, was passed whereby vocational rehabilitation could render physical restoration services to its handicapped people. At that time we became very much interested in the type of services, the standards of services, and so forth, and in each of the various states there was a medical advisory committee established which did peer review at that time. We had this fine medical advisory committee who reviewed all the recommendations of the physicians as they related to physical restoration and also reviewed the results. This was accepted by the physicians very well, because we did have an excellent type of committee. They also helped in the development of pay schedules for physicians at that time, and we in the National Rehabilitation Association are interested that services to the handicapped be good services and that we get them at a rate we can afford to pay.

As I mentioned in the beginning, it is not a professional organization as such, but it is an organization of professionals and others who are interested -- any person in this group would be eligible for membership. We at the present time have about 35,000 members throughout the United States. And I would like to have Mr. Hall, who is the Executive Director of the National Rehabilitation Counseling Association, mention the part that they play in this organization.

MR. FLETCHER R. HALL

NATIONAL REHABILITATION ASSOCIATION

I think that one of the significant interests of rehabilitation, both rehabilitation medicine and vocational rehabilitation state/federal programs in peer review and PSRO, actually has to do with the cost/benefit ratio implications. In oversight hearings before the Congress during last year, Mr. James Dwight, who is the Administrator of the Social and Rehabilitation Services, called the vocational rehabilitation program one of the most successful human resource programs in the history of the federal government; I think he was particularly referring to the cost/benefit ratio.

Obviously the importance of the cost/benefit ratio becomes even more significant with the passage of Public Law 93-112, which mandates that the most severely handicapped and disabled people in the population at large are to be screened and served in the rehabilitation process, whether that be rehabilitation medicine or the vocational rehabilitation aspect of state/federal vocational and private rehabilitation programs in the country.

The prime deliverers of service, other than in the rehabilitation medicine component of rehabilitation, are rehabilitation counselors. There are some 13,000 rehabilitation counselors working in the country today, both in the state/federal vocational rehabilitation program and in the private rehabilitation programs such as Good Will and those associated with rehabilitation centers and hospitals that have created rehabilitation medicine departments.

In the past year we have moved for the first time to a national certification program for rehabilitation counselors which contains both a peer review and a consumer review component. We feel that both of these components are necessary in any program of this type. I suspect that as a result of an interest shown about practitioners who obviously are working very closely with physicians, social workers, and many other allied health professionals, that we will also, in view of our past history of the medical review by medical advisory committees, be looking for an opportunity to participate in the non-physician components of the peer review process.

DR. BERNARD J. SHANNON

AMERICAN OPTOMETRIC ASSOCIATION

The American Optometric Association represents over 18,500 optometrists in this country. We are one year younger than the American Nurses' Association, having been established in 1897. The optometrists of this country care for about 70 per cent of the vision care that is rendered in this country. We, of course, have had a long standing and a regularly updated code of ethics, as you would expect.

The American Optometric Association I think is probably one of the few organizations that did support Mr. Bennett in his activities legislatively in the PSRO law, and we did through the entire process. We did feel at that time and still strongly do feel that providers of health services such as those here, certainly those of podiatry and dentistry also, have primary roles in every step of every review program which relates to the care they render. Therefore, there must be an active involvement in all PSRO activity. At our initiation well over a year ago, I met with Dr. Simmons and Dr. Edwards on this particular subject. Quality assurance has been a goal of optometry long before the words peer review and PSRO came into use.

At the present time we have over 30 states that have mandatory continuing education for license renewal -- not for membership in the association but for license renewal, and some of these go back into the 1940's. Currently we have a National Commission on Continuing Education which is working on this very important area of continuing education. My profession has supported and encouraged peer review of optometric services for many years, as a matter of fact long before medical administrators were ready to admit or recognize the need for such activity.

Community health optometry seminars for a number of years back in the 1960's have discussed peer review for state leaders. Optometry has been very responsive to pertinent parts of the report that came out in the sixties, "Health is a Community Affair." The AOA has made it possible for every state in this country at this time to have a peer review mechanism which is either operational or is ready to be at a moment's notice when needed. Many states have already established their own standards. Many optometric peer review programs have been in process in Title 19 programs

since its inception. Most of the schools of optometry are instructing the students in the concept of peer review. At the present time, the Massachusetts College of Optometry in Boston is working cooperatively with Harvard University on a program in this area. The Journal of the American Optometric Association and the AOA news have carried articles for the information of every member, of every optometrist, on a regular basis for a number of years. So, all of the practitioners in this country have been informed of the concept of peer review, not just those who are at the top.

The AOA House of Delegates has passed resolutions which endorsed the concept of peer review. Our Association's position on National Health Insurance, by way of a House of Delegates resolution, also states that a program of national health insurance must include true peer review before our Association will endorse that proposal. We realize that costs are important in this total subject, and optometry has been very responsive in this area. I think broadly across the board the increases in cost of optometric care have been some of the smallest. A couple of years ago when the Medi-Cal program made a retroactive study of its program, they found that optometry was the profession that most followed the guides and the projections that were set up for that program.

The Board of Trustees of AOA has passed a number of motions and resolutions which relate to peer review and positions of support too, I might add. AOA has just published a book which is called Current Optometric Information and Terminology, which is a very important part of establishing criteria for peer review programs.

In the past couple of months the AOA Community Health Division has prepared a procedure manual on peer review. This has been distributed to all state associations for their use. We currently have a standing committee in the American Optometric Association whose sole responsibility is in the area of peer review. The chairman of that committee happens to be an optometrist from Utah who does sit on the UPRO Board of Directors, and we certainly concur with the suggestions made by Dr. Winterfeldt on that Utah experience.

The American Optometric Association requests the opportunity to make specific recommendations on the involvement and contributions of optometrists in PSROs at all levels. We realize that some of these areas will be discussed this

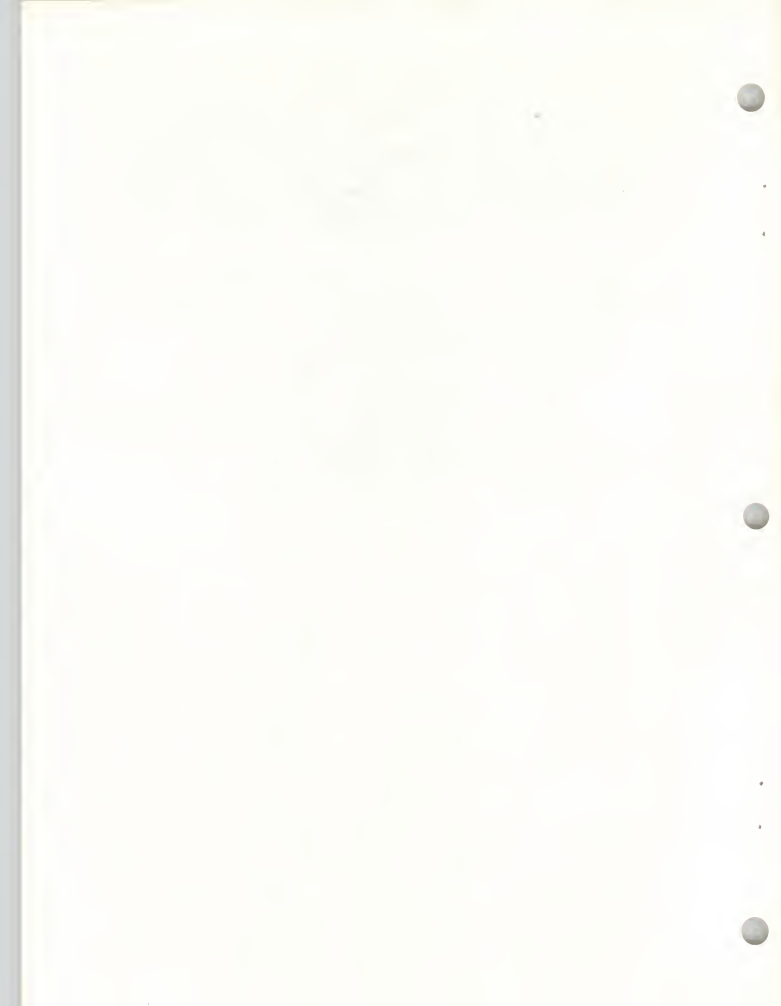
afternoon, but we feel that a formal recommendation should be solicited. As you can undoubtedly tell, the profession of optometry has been interested and active in peer review for a long time. We know we must be responsive to the patient's needs. We feel that professions like optometry and those others here must be active in every level of PSRO structure. We will actively support an equitable PSRO program.

DR. LOUIS A. REIBLING

AMERICAN SOCIETY OF ALLIED HEALTH PROFESSIONS

As you all may know, the American Society of Allied Health Professions was formerly called the Association of Schools of Allied Health Professions. Under our new name of just one year, we are an association composed of educational institutions and professional organizations in allied health.

The peer review activities of the educators are well documented and are not really applicable to this meeting, although I suddenly have a thought that maybe we in education need some PSRO. The peer review activities of the professional organizations have been more readily given by their representatives in attendance today. The educational component of ASAHP, in addition to the professional organization, is very much interested in the PSRO's relationship with curriculum and the resulting changes that will come; likewise with the more immediate need in the continuing education area. And we will work very closely as needed with your offices.



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